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ABSTRACT

This paper points out that both formal and informal historical precedents in community mental health have emphasized citizen participation as an essential element of the system's success. It reviews citizen involvement procedures in use in one midwestern catchment area, and concludes that citizen representation appears to be inadequate, in particular in terms of geographical and occupational variables. It then contrasts the community mental health approach with a seemingly more effective strategy used by community development workers in the same community. Differences between the two methods are analyzed in relation to an active-passive continuum of staff effort to gain citizen input. The mental health approach is characterized as a passive strategy, while the community development method is shown to be an active one. Conclusions are, first, that community mental health staff should take more active steps toward citizen-provider interaction; and, second, that specific strategies should be developed to govern the extent and type of consumer control to be utilized within the system. (Author)

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Consumer Control in Community Mental Health:

Active or Passive?

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ABSTRACT

CONSUMER CONTROL IN COMMUNITY MENTAL HEALTH: ACTIVE OR PASSIVE?

Both formal and informal historical precedents in community mental health have emphasized citizen participation as an essential element of the system's success. Now, fifteen years following the seminal legislation, questions have arisen concerning the extent to which this goal has been realized.

In order to examine this issue, a review of citizen involvement procedures in use in one midwestern catchment area was undertaken. Citizen representation appeared to be inadequate, in particular in terms of geographical and occupational variables. The Community Mental Health approach was then contrasted with a seemingly more effective strategy used by community development workers in the same community. Differences between the two methods were analyzed in relation to an active-passive continuum of staff effort to gain citizen input. The mental health approach was characterized as a passive strategy, while the community development method was shown to be an active one.

It was concluded that; 1. community mental health staff should take more active steps toward citizen-provider interaction; and 2. specific strategies should be developed to govern the extent and type of consumer control to be utilized within the system.

CONSUMER CONTROL IN COMMUNITY MENTAL HEALTH: ACTIVE OR PASSIVE?

In 1955, the Congress enacted the Mental Health Study Act, which authorized the formation of the Joint Commission on Mental Illness and Health to study mental health service provision in the U.S. The report of the Commission was published in 1961 and contained recommendations for an extensive reorganization of this country's approach to the treatment of the mentally ill. Although many specific recommendations were given, decentralization of services was probably the most prominent topic. The Commission strongly suggested that future services be community-based.

Many of these recommendations were translated into law when the Congress passed the Community Mental Health Centers Act in October of 1963 (Public Law 88-164, Title II). This legislation initiated the move toward a decentralized and citizen-responsive mental health system. States were urged to formulate service plans which made essential services available to all in sufficient quantities to meet existing needs (Brown and Cain, 1964). Citizen participation was considered crucial to the success of the new system. Citizen advice and guidance in planning for each community was heralded as the answer to service shortages for the poor and disadvantaged (Smith and Hobbs, 1966).

Now, fifteen years following the seminal legislation, the Community Mental Health network presents a picture which differs substantially from the intentions of pioneers. The adequacy and representativeness of citizen involvement is being questioned (Bertlesen and Harris, 1973; Holton, New and Hessler, 1973; Kane, 1975). Much of the difficulty in this area appears to stem from ambiguity in rules and regulations which govern the system of provider-citizen communication. Although service community involvement was encouraged from the beginning, no specific strategies were enumerated. Great variability currently exists in the methods

used in achieving citizen participation.

Generally, a citizen board is formed to advise mental health staff members in a given catchment area. However, without specific guidelines, mechanisms which determine the type and extent of participation may lead to inadequate representation and/or a board which has little or no power in formal decision-making. In order to explore these issues further, the present paper will undertake an analysis of participation methods in use in one midwestern catchment area. The Community Mental Health approach will then be contrasted with a model used by community development workers in the same community. The implications of this contrast will then be discussed in terms of future planning.

The Community Mental Health System

The community system of interest here serves a midwestern county of approximately 200,000 population. The service area is predominantly white, middle class and contains two cities, one of 100,000 residents and another of 35,000 people. The area is primarily industrial and contains a large number of manufacturing concerns. Between thirty and forty human service agencies are located in the larger city, including a state hospital for the emotionally ill which has a capacity of near 1,000 beds.

Presently, community mental health services are provided for the county through a central administrative office staffed by personnel hired via county and state funds. Some services are offered directly through the central office. However, the majority of the required range of essential services is provided by way of contracts with existing separate agencies.

Citizen involvement is accomplished through a twelve-member board, which oversees staff activity, reviews and approves contracts and conducts general business in monthly meetings. Board members are selected from applicants by the County Board of Commissioners as vacancies arise. Members are appointed for three-year terms

and then, are replaced or reappointed. The staff brings the issues to the Board, the Board makes the decisions with staff advice, and the staff carries out the bidding of the Board.

The system of Board member selection is essentially passive with respect to overt involvement of mental health staff members. Citizens must learn of a vacancy, submit an application, undergo at least one interview and if selected, serve on the Board. Throughout this process, community mental health staff members are not overtly active. No mechanism exists to insure that the service community is adequately informed. The vacancy is simply advertised via the mass media for a specified period of time. Professional staff members do not go into the community to distribute this information or to explain what is involved.

Following appointment, the board member must attend meetings during regular working hours (with the exception of an occasional evening meeting) and must be concerned with mental health business conferences and other activities during the workday. Not only does such a schedule discourage application from someone who must work at a regular job, but it also may cause difficulty for citizen input in general.

It is the contention of the present authors that such procedures can lead to serious problems with the type and extent of citizen involvement in mental health planning and service provision. This contention is supported by some recently compiled data. Table 1 presents a comparison of the Board (as a group), the County, the largest area city, and a group of census tracts (considered high risk) in terms of eleven census factors. The eleven factors presented were selected because of their role as indicators of need for mental health services (Michigan Department of Mental Health, 1977). Community Development areas were chosen because of their status as communities at risk of developing serious problems or already experiencing significant problems which merit the attention of the mental health system.

In general, Table 1 shows that the Board, as a group, is near or above the

Table 1

Comparison of Statistics from 1970 Census for

Twelve Board Members, County, City One and

Community Development Target Areas

Factor	Census Statistics			
	Board Average	County	City 1	Target Tracts**
Median income	$13,052	$11,037	$9,852	$6,695
Housing value (Median)	$21,275	$16,400	$14,300	$8,675
Education (Years)	13.3	12.3	12.3	9.9
Percent Black	1.2	4.8	10.0	48.4
Percent foreign born	3.2	3.0	4.0	3.0
Percent unemployed	4.2	4.9	5.8	9.6
Percent professional, technical and kindred	24.3	16.7	18.4	12.8
Percent unskilled	13.7	18.1	20.0	32.1
Percent below poverty (Families)	3.4	5.8	7.9	19.7
Percent single parent families	8.6	11.0	15.0	36.0
Percent renter occupied (Housing units)	19.4	27.0	40.4	49.5

**Scores represent an arithmetic average of four census tracts

comparison areas on the following indices; median income, housing value, education and percent professional workers. These data also show the Board as a whole to be near or below the three comparison areas in minority representation, unemployment, percent of unskilled workers, percent of families below the poverty level and percent renter occupied units.

Additional data regarding geographical representation are presented in Figure 1. These data illustrate that Board members only haphazardly represent the service area population. Part A of Figure 1 indicates that Board member residences are clustered in or near the largest city of the area, which they should be if the most populated areas are to receive adequate representation. However, Part B indicates that most Board members do not in fact live within the most populated areas of the city, nor within the tracts considered to be the most problematic.

An examination of the occupations of Board members supports the contention that the general population of the service area is not well represented. For example, of the twelve Board members in office at the time of this study, one is a medical doctor, one is a college dean, another is a psychiatrist and one is a social worker employed in a nearby county.

The above data are indicative of serious shortcomings within a system that was originally designed to allow citizens to have a voice in service provision in their community. The true impact of these problems can only be implied via comparison with other human service efforts which have been carried out in the same community.

The Community Development Approach

By way of contrast, the present authors have also been involved with a seemingly more effective approach to citizen involvement. Each year for the past few years, funds have been available from the municipal government of the largest area city for improvement of certain target neighborhoods. Here workers have taken an active role in citizen participation and the results are substantially more productive in terms of

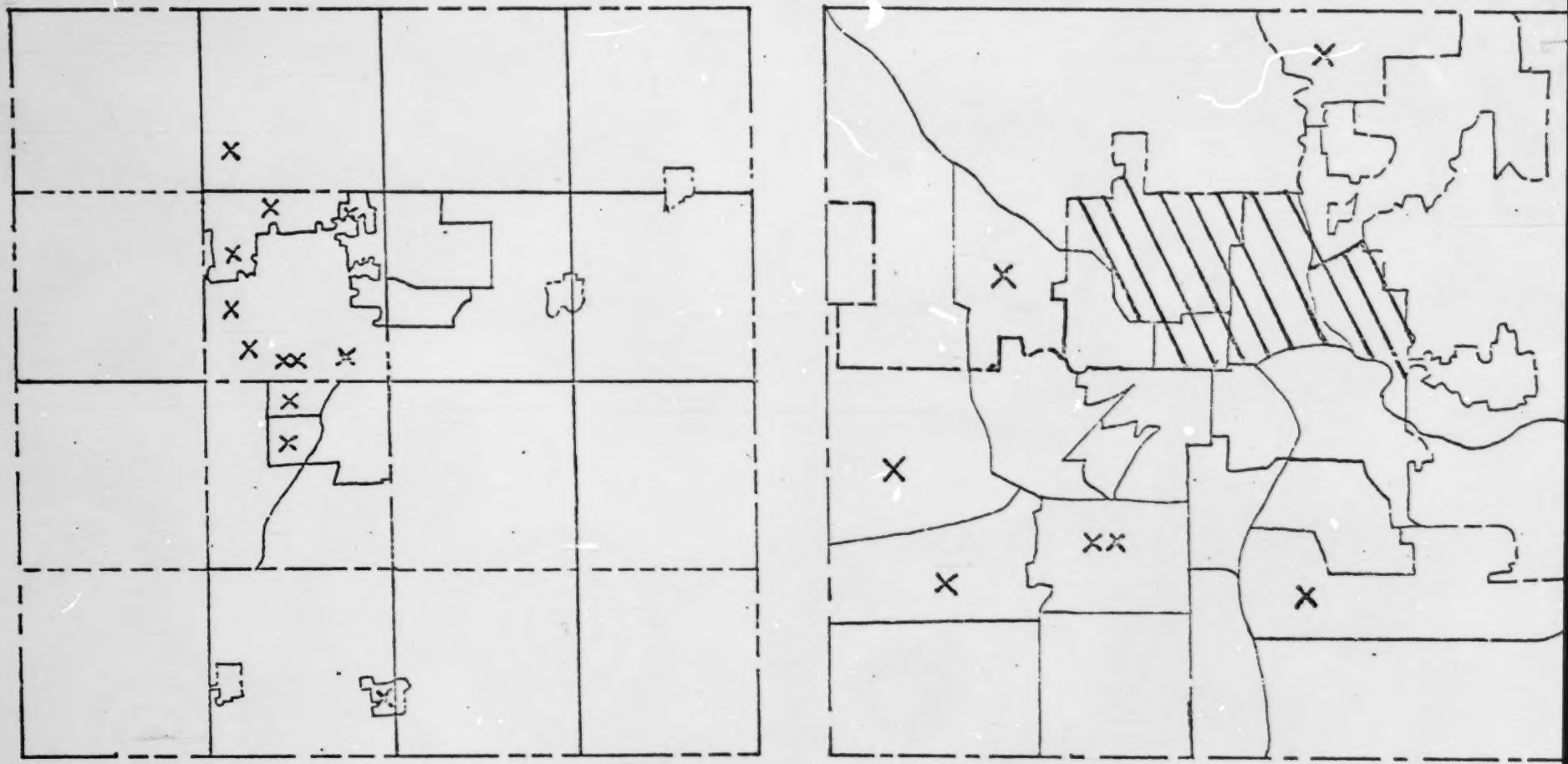

Figure 1. The geographical locations of mental health board member residences for the County (A) and for City number one (B). The Community Development target areas are represented by the diagonal lines in figure B.

the number of citizens involved and the extent of their control.

Before spending the available monies, responsible fiscal parties were required to determine need as expressed by target-area citizens. The rules governing this process were explicitly stated. It was required that provisions be made for extensive citizen participation at all levels of program planning and execution. A written program plan was required prior to funding; public meetings were also required; and active recruitment of citizens from target areas was mandated (U.S. Government, 1977). The following quotes are representative of the stipulations regarding citizen involvement.

- "There shall be involvement of low and moderate-income persons, members of minority groups... the elderly, the handicapped and other persons directly affected..."

- "Citizens shall be provided adequate and timely information, so as to enable them to be meaningfully involved in important decisions at various stages of the program."

- "The applicant shall provide a process for citizen participation at the community-wide level and at the neighborhood level where comprehensive neighborhood revitalization areas have been designated."

The guidelines also indicated that where citizens did not have the expertise to participate effectively, training programs were to be implemented. Again a quote from the regulations is illustrative.

> "To facilitate citizen participation, the plan shall have provided for technical assistance through staff or other resources... technical assistance may also be directed toward assisting citizens in organizing and operating neighborhood and project area organizations and in carrying out community development program activities."

The results from one of the target neighborhoods is an example of what such an approach can accomplish. The City dispatched workers to the community to mobilize

interested citizens. These workers went from door to door for a short period of time. Subsequently, well-publicized meetings were held within the neighborhood. Workers then aided citizens in the formation of a community association which came to function as the sanctioned voice of the community. This association later incorporated in order to receive federal funds. Need assessment hearings were then held on three different occasions and community residents were helped in structuring their input so that it might be maximally useful to the municipal government. The community association elected officers and was trained briefly in the methods necessary to maintain the organization. Following the completion of initial procedures, city workers were still helpful as consultants when problems surfaced.

As a measure of effectiveness, one need only examine the tangible results of this process. In need assessment hearings, the public prioritized the projects on which they thought federal dollars should be spent. The number one priority was a neighborhood center for human services and general community usage. One year later, a building was purchased and is now being used extensively. During public meetings, disrepair of sidewalks and streets was also indentified as a problem. Construction crews have since repaired many of the damaged areas and installed new street lamps. Other results have been similarly appropriate to citizens wishes. At last report, the citizen association was still active and community residents reported satisfaction with the entire process. Plans are now being made for future endeavors. Other communities have not fared as well, however, work is still in progress.

Passive and Active Approaches Contrasted

The above examples provide illustrations of citizen participation on an active-passive continuum. Specific comparisons of requirements are presented in Table 2. The Community Mental Health method employs no consistent specific strategy. Direct interaction between the general community and provider is minimal. The opportunity

Table 2

A Comparison of Required Steps in the Development of Citizen Participation Programs for Community Mental Health and Community Development Program Planning

Community Mental Health	Community Development
1. County Commission appoints citizen board.	1. Provide citizens with adequate opportunity to participate and prepare a written citizen participation plan.
2. Board members must live in the County.	2. Provide for a process for citizen participation at the neighborhood level.
3. Board shall be representative of providers, consumers, involved agencies or occupations, and the general public - no fixed proportions.	3. Encourage particpation of low income, elderly, handicapped, and other special groups.
4. Perform a required need assessment.	4. Provide for contunity of citizen participation throughout all stages.
	5. Citizens shall be given technical assistance in participation.
	6. Conduct neighborhood meetings and public hearings.
	7. Provide for full access to program information by citizens.
	8. Give citizens or citizen groups the opportunity to monitor and evaluate projects to determine if objectives have been met.

exists for misrepresentation and/or insufficient citizen input because of limited contact. Client service demand and the twelve-member board are the only points of direct contact between the system and the citizenry. The role of the mental health staff member is passive.

On the other hand, the community development model emphasizes extensive contact with the community. With this strategy, citizen input is actively sought and citizens are aided in their initial and most crucial contact with governmental agencies. In effect, community residents are trained in effective participation. Help is also available on a continuing basis in the form of consultation.

Conclusion

Although it is drawn from an isolated area, the above characterization of consumer control in community mental health appears to agree with other reports. For example, Holton, New and Hessler (1973), in a study of six community mental health service communities in four states, concluded that citizen participation was predominantly "elitist" and "advisory". Within the elitist framework, according to these authors, "community leaders and resident volunteers serve on boards largely for purposes of moneyraising, public relations, and imagebuilding". The advisory model is similar to the example described in this paper.

If, as originally planned, the Community Mental Health system is to be citizen-controlled, a more active stance must be taken. Professionals must seek citizen input and train members of the service population in effective strategies of involvement. A passive approach cannot insure that the consumer has a voice in service design and implementation.

REFERENCES

Bertlesen, K. & Harris, M.R. Citizen participation in the development of a community mental health center. Hospital and Community Psychiatry, 1973, 24(8), 553-555.

Brown, B.S. & Cain, H.P. The many meanings of comprehensive. American Journal of Orthopsychiatry, 1964, 43, 834-839.

Holton, W.E., New, P.K. & Hessler, R.M. Citizen participation and conflict. Administration in Mental Health, 1973, Fall, 96-103.

Housing and Urban Development. Community development block grants: Eligible activities, applications for entitlement grants, urban development action grants. Federal Register, U.S. Government Printing Office, October 25, 1977 (Part III).

Kane, T.J. Citizen participation in decision making: Myth or strategy. Administration in Mental Health, 1975, 14, 29-34.

Smith, M.B. & Hobbs, N. The community and the community mental health center. American Psychologist, 1966, 21, 499-509.

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